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Section 8-54

Purpose: This protocol is designed to guide EMS clinicians in expanding their scope of practice to deliver patient-centered, comfort-focused care in the prehospital setting for patients and families identified as receiving hospice or palliative care. Importantly, while it does not restrict EMS teams from pursuing traditional interventions when indicated, it provides clear guidance and options to effectively manage end-of-life care complications, empowering teams to address the unique needs of patients who have chosen comfort care at home.

Definitions:

A. Hospice Care – focuses on providing comfort and support to patients with a terminal illness who have chosen to forgo curative treatments. Its goal is to enhance quality of life, manage symptoms, and provide emotional and spiritual support to patients and their families during the end-of-life journey.
B. Palliative care - is specialized medical care aimed at improving quality of life for patients with serious or chronic illnesses. It focuses on relieving symptoms, managing pain, and addressing emotional, psychological, and spiritual needs at any stage of the illness, regardless of prognosis or treatment goals.
C. Patient Advocate - means an individual designated to make medical treatment decisions for a patient under Section 496 of the revised probate code, Act No. 642 of the Public Acts of 1978, being section 700.496 of the Michigan Compiled Laws.
D. Do-not-resuscitate order - means a document executive pursuant to Act 193, directing that in the event a patient suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, nursing home, or mental health facility owned or operated by the Department of Community Health, no resuscitation will be initiated.

Indications: This protocol is designated for patients under active hospice or palliative care who have chosen to prioritize comfort care at home.

I. Verifying Decision-Maker Authority

A. Patient Self-Determination: Assess if the patient is alert and oriented x4 (person, place, time, purpose) and appears capable of making informed decisions. If so, the patient should direct their own medical care.

B. Patient Advocate: If the patient is unable to make decisions:

1. Verify the presence of a Patient Advocate or designated Health Care Proxy. Obtain the advocates name, contact information and any relevant documentation. Allow the patient advocate to assist with medical decision-making.

C. Emergent Consent: If the patient is incapacitated and no patient advocate is available:

1. Assume implied consent for emergency situations, exit this protocol, and provide care according to standard of care.

II. Verify Patient Code

A. Code Status Verification: Confirm early in the encounter the patient’s designated code status, and paperwork. (See MI Do-Not-Resuscitate Protocol - Section 7-7)

1. **Full Code:** The primary goal is to prolong life by all medically effective means. All resuscitative and life-sustaining measures are to be used as needed.
2. **DNAR with Comfort-Focused Treatment:** The patient has opted not to receive CPR. The primary goal is to maximize comfort. Treatment may include pain relief through

medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance like oxygen therapy.

3. **DNAR with Selective Treatment:** The patient has opted not to receive CPR and does not wish to use intubation or mechanical ventilation. The primary goal is to treat medical conditions while avoiding burdensome measures. Treatment may include IV fluids, cardiac monitoring, cardioversion, and non-invasive airway support such as CPAP, BiPAP, or heated high-flow oxygen.
   DNAR with Full Treatment: The patient does not want CPR, but until the heart stops, the goal remains to prolong life by all medically effective means. Treatment may include intubation, advanced invasive airway interventions, mechanical ventilation, and other advanced interventions as needed

III. Verify Patient and FamilyGoals of Care:

A. At the beginning of the encounter, clearly identify the patient's or family's care priorities and their expectations from the EMS team.

1. **Improved Pain Control:** Determine if managing pain is the primary goal, and if so, implement appropriate pain management strategies.
2. **Improved Symptom Control:** Assess if controlling other symptoms is a priority and address these symptoms using suitable medical interventions.
3. **End-of-Life Care and Death at Home:** Confirm whether the patient wishes to remain at home for end-of-life care, ensuring that interventions align with this preference.
4. **Family Reassurance:** Provide reassurance to the patient and family. Communicate that their efforts in caregiving are commendable, explain that the events occurring are expected, and address any questions they may have to ease their concerns.

IV. Early Contact and Engagement with the Patient's Hospice or Palliative Care Team

A. **Request Phone Assistance:** Contact the hospice or palliative care team to provide an update on the patient’s current situation and request guidance for managing the patient’s condition over the phone.

B. **Request On-Scene Assistance:** If needed, request the hospice or palliative care team to respond on-site. Be aware that on-scene availability may be limited, and response times could exceed EMS's 30-minute home management trial period.

C. **Document Contact Information:** Record the name and phone number of the hospice or palliative care team member for inclusion in the medical documentation and for handoff to the ED team, if applicable.

V. Verification of Patient & Family Transport Preference:

A. Confirm early in the interaction whether the patient or their family desires transport to the Emergency Department.

B. If Decision for Transport is **YES** Proceed to Appropriate Protocol but collect the following information before transport:

1. **Patient Advocate or Family Contact Information:** Gather contact details for immediate family or responsible parties.
2. **Advance Directives:** Confirm the existence and details of any advance directive paperwork.
3. **Hospice or Palliative Care Contact Information:** Obtain contact information for the patient's hospice or palliative care team.

C. If Decision for Transport is **NO**, continue to follow the hospice and palliative care section of this protocol to continue care on-site or facilitate other non-transport **options.**

VI. Provide Limited Trial of Palliative Symptom Management at Home

A. At the discretion of EMS clinicians, a limited trial (20–30 minutes) of symptom-specific comfort care should be provided, consistent with the patient's advanced directives and care priorities.

B. Care should involve collaboration with family members and, when available, the hospice team. Medications from the patient's "Home Hospice Kit" or the EMS supply may be used.

C. After Limited Trial of Care, Assess Patient's Condition:

1. **Condition Improved:** If the patient's condition or situation has improved after the limited trial of care and the patient or family requests to remain at home, contact medical control for assistance with the refusal of care sign-off process.
2. **Condition Unchanged or Worsened:** If symptoms remain uncontrolled after the limited trial of care, recommend transport to the ED for further management.
3. Care can be handed off to the patient's hospice or palliative care team in person or telephonic if appropriate and available.

VII. Palliative Symptom Management Recommendations

A. Pain Management

1. **Assessment and Reassessment:** Use the Wong Pain Scale to assess pain severity.
   a. Moderate pain ≤ 7 , Severe Pain ≥ 7.
   b. Reassess pain after administering medication, accounting for the onset of action and changes in the patient's condition.
2. **Treatment Guidelines:**

	Morphine (IV/IM)	**Fentanyl (IV/IM)**
Moderate Pain:	4 mg	50 mcg
Severe Pain:	8 mg	100 mcg
Titration:	4 mg every 15 minutes IV	50 mcg every 15 minutes IV

3. **Dosing Considerations:** Keep in mind oral dosing conversions when deciding on initial IV/IM opiate dosing.

Selected Equianalgesic Opioid Dosing[a]

Opioid	Equianalgesic Equivalence (mg)	
	Parenteral	Oral
Morphine	10	25
Fentanyl	0.15	NA
Hydrocodone	NA	25
Hydromorphone	2	5
Oxycodone	10[b]	20
Oxymorphone	1	10

[a] Equianalgesic data presented in this table are that which are most commonly used by healthcare practitioners, and based on best evidence available, but they are still **approximate**. These are NOT opioid DOSES for individual patient use; this is equivalency information. The clinician is urged to access the original work: McPherson ML. *Demystifying opioid conversion calculations: A guide for effective dosing, Second edition.* Bethesda, MD: American Society of Health-System Pharmacists, 2018.

[b] Not available in the United States.

B. Nausea and Vomiting

1. **Assessment:** Identify and address triggers, including medications or disease progression.
2. **First Line Treatment:** Zofran:4 mg IV/IM, repeatable after 15 minutes if ineffective.
3. **Second Line Treatment:** Haldol 2 mg Sublingual if available from the home hospice kit.
4. **Third Line Treatment:** Lorazepam 1 mg Sublingual if available from the home hospice kit.

C. Anxiety and (moderate to severe) Agitation

1. **Assessment:** Identify underlying causes, such as breakthrough pain, shortness of breath, or terminal delirium.
2. **Treatment Guidelines:**

	Midazolam (IV/IM)	**(IV)**	**Ketamine (IV/IM)**
Moderate	2 mg		
Severe	5 mg		
Severe or Refractory			0.5 mg / kg (Max 50 mg)

D. Severe Agitation or Breakthrough Pain

1. **Assessment:** For patients with severe agitation or pain (Wong Pain Scale ≥ 7) unresponsive to home medications, EMS teams may administer a single-dose trial of low dose ketamine in conjunction with the outlined medication guidelines with the approval of online medical control.
2. **Ketamine Treatment Guidelines:** 0.5 mg/kg IM (maximum single dose: 50 mg)
3. Reference and adhere to local ketamine protocols and procedures when administering ketamine.

VIII.Clinical Considerations & Treatment Pearls

Condition	Recommendations & Treatment Pearls
Breakthrough Pain	Assist with 'home kit' medications. Higher opioid doses may be required. Start with 10% of total 24-hour dose (information can be found by asking the patient, the family, or the hospice nurse). Convert oral dosing to IM/IV.
Anxiety	Identify possible causes such as breakthrough pain, shortness of breath, or terminal delirium.
Delirium & Agitation	Ensure patient uses hearing aids/glasses. Address calmly and limit noise/activity.
Dyspnea	Apply oxygen for hypoxia. Morphine can reduce dyspnea sensation.
Nausea &Vomiting	Assist family with nausea medication or administer Zofran if no home kit is available.
Oral Secretions	Reassure family; avoid deep suctioning as it is usually not distressing to the patient.
Fever	Fever is normal in actively dying patients. Treat as needed; consider cold compresses.
Constipation	Constipation may cause agitation. Recommend the use of Dulcolax suppositories if available.
Urinary Retention	Urinary retention may cause agitation. Assess urinary output; hospice nurses can use a bladder scanner or place a Foley catheter if needed.
Acute Hemorrhage	Severe hemorrhage can occur in certain conditions. Maintain airway with gentle suctioning. Consider dark towels and support caregivers. Consulhospice team.
Family Distress	Support family as with any unexpected death. Request hospice agency assistance if needed.
Naloxone Use	Avoid using naloxone in hospice and palliative care patients unless necessary.

IX. Referenced SCCMCA Protocols

B. Dead on Scene & Termination of Resuscitation – Section 7-6
C. Do-Not-Resuscitate- Section 7-7
D. Pain Management – Section 7-13
E. Refusal of Care; Adult & Minor – Section 7-19
F. Documentation and Patient Care Records – Section 7-15
G. Michigan Physician Orders for Scope of Treatment – Section 7-25
H. Ketamine – Section 9- Refrence

Hospice & Palliative Comfort Care Pathways